

Verification of Completion of Massage Program

To be completed by applicants who completed an approved formal education program.
See the checklist at the end of this application for additional instructions.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name:

First

Middle

Last

Mailing Address:

Street/PO Box

City

State/Zip

EDUCATION

To be completed by the Official Program Representative:

Start Date:

MM/DD/YYYY

End Date:

MM/DD/YYYY

Please list the total number of hours of training in each of the following categories:

Anatomy, Physiology and Kinesiology:

Pathology:

Massage Theory (including the 5 Basic Swedish Massage Strokes and hands on instruction):

Professional Standards, Ethics and Business Practices:

Sanitation and Universal Precautions (including CPR and First Aid):

Clinic

Other, Please specify (Use additional sheets if necessary):

Total hours of all training:

By signing below, I certify that the applicant named above has successfully completed a program of education and training as outlined in R156-47b-302 or 302a.

I further certify that the applicant is qualified and competent to practice as a licensed massage therapist.

Signature:

Date:

Name of School:

School License Number:

Address:

Street/PO Box

City

State/Zip

(Seal)

Please affix the school seal to the left, **attach a COPY of your Letter of Accreditation and seal this form in an envelope with the school seal over the envelope flap and send directly to DOPL or provide to the applicant to include in their application.*